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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

MONTHLY TB MEDICATION REQUEST

☐ NEW ☐ REFILL

FOR NEW ORDERS CALL 800-392-5586 OR FAX 660-886-2121
PLEASE MAIL OR FAX REFILL REQUESTS

HEALTH UNIT	DATE

CLIENT INFORMATION

NAME	DATE OF BIRTH	WEIGHT

ADDRESS (STREET, CITY, ZIP CODE)	SOCIAL SECURITY #

PRESCRIPTION INSURANCE INFORMATION (ATTACH COPY OF CARD AT BOTTOM OF PAGE IF AVAILABLE)

INSURANCE PLAN (ie: MEDICAID, BLUE CHOICE, PCS, UNITED HEALTHCARE)		CLIENT'S RELATIONSHIP TO CARDHOLDER (ie: SELF, SPOUSE, DEPENDENT)

CARDHOLDER ID #	GROUP #	CLIENT'S ID # (IF DIFFERENT THAN CARDHOLDER)

PHYSICIAN INFORMATION

NAME	TELEPHONE #

ADDRESS (STREET, CITY, STATE, ZIP CODE)

ADDITIONAL MEDICATIONS BEING TAKEN	DRUG ALLERGIES

TOTAL DURATION OF THERAPY _____ MONTHS

MEDICATION ORDER (ATTACH COPIES OF PRESCRIPTION IF AVAILABLE)

ITEM	RX NUMBER	ITEM	RX NUMBER

POSSIBLE ADVERSE EFFECTS

☐ Tiredness	☐ Loss of Appetite	☐ Fever or Chills	☐ Weight Loss	☐ Pale Skin
☐ Itching	☐ Easy Bleeding or Bruising	☐ Stomach Pain	☐ Diarrhea	☐ Yellow Skin or Eyes
☐ Bone or Sore Muscles	☐ Rash	☐ Nausea or Vomiting	☐ Change in Color of Urine or Stool Weakness	☐ Vision Changes
		☐ Nervousness		☐ Trouble Breathing

PERSON COMPLETING FORM

NAME	TELEPHONE #

I _____ , County/City Health Department/University Health Centers, affirm by my signature, that I understand it is a requirement of me while dispensing this medication to the above patient, that I must evaluate the patient at least once a month for the possible adverse effects listed above. I understand it is also a requirement to send a copy of this signed medication request form (TBC-8) monthly to the Local Public Health Department in my county.

PLEASE PLACE COPY OF INSURANCE CARD HERE

FAX FORM TO: 660-886-2121
OR MAIL TO: RED CROSS PHARMACY
161 SOUTH BENTON
MARSHALL, MO 65340